

## **TUITION BASED PRESCHOOL PROGRAM ENROLLMENT PROCESS**

☐ Complete the **MANDATORY** Intent to Register Form - available to you at the following link [TUITION-BASED INTENT TO REGISTER FORM- 2023-2024](#) or by scanning the QR Code below:



☐ **If space available:** A preschool staff will contact you in receipt of your “intent to register” and notify to submit your \$150 registration fee.

☐ **Begin Completing the Registration Packet** - Can be found on the LJSD Preschool website ([www.preschool.ljsd.org](http://www.preschool.ljsd.org)) under the “Registration Packet” link or pick up a printed copy at the following address:

Lowell Joint School District Office  
11019 Valley Home Ave.  
Whittier, CA 90603-3042

☐ Use the provided **REQUIRED DOCUMENTS FOR PRESCHOOL REGISTRATION checklist**. **\*The Packet must be completed in blue or black ink.**

☐ **After Registration Packet is COMPLETE:** Schedule a Family Intake Appointment with Ms. Christina Lopez, [clopez@ljsd.org](mailto:clopez@ljsd.org) to review your documentation after June 5, 2023. Your appointment will take place at the Lowell Joint District office. (address above)

**\*ONLY PARENTS OR LEGAL GUARDIANS CAN FINALIZE THE ENROLLMENT.**

**ONLY COMPLETED PACKETS ALONG WITH THE REQUIRED DOCUMENTS WILL BE ACCEPTED. IF  
ADDITIONAL ASSISTANCE IS NEEDED, CONTACT Ms. Christina Lopez, [clopez@ljsd.org](mailto:clopez@ljsd.org)**

### **REQUIRED DOCUMENTS FOR PRESCHOOL REGISTRATION**

**\*Packet must be completed in blue or black ink**

- ☐ **Read 2023-2024 Parent/Guardian Preschool Handbook. Download and print acknowledgement page.**
- ☐ **Original Birth Certificate for ALL children living at home and under the age of 18**
- ☐ **Signed Admission Agreement**
- ☐ **Tuition/Fee-Based Contract**
- ☐ **Updated Immunization Record of the child enrolling for Preschool - (TB Exam results must be written on the Immunization card if the physician sees necessary.)**
- ☐ **Current Physical Exam - Signed, stamped and dated by a doctor on the provided state licensing form (Form Lic701)**
- ☐ **Attached consent forms need to be completely filled out, signed and dated**
- ☐ **Attached state licensing forms need to be completely filled out, signed and dated**
- ☐ **Emergency contacts with phone numbers - We must have at least three (3) Emergency contact phone numbers. (Form Lic700) The contact person will be given the right to pick up the child when the parent cannot. (Emergency contacts must be 18 years or older and have valid identification.)**
- ☐ **Individualized Educational Plan - (IEP) A copy of the IEP must be submitted if applicable.**
- ☐ **Optional: Parent Volunteering in the classroom with children interaction requires immunizations: (SB 792 requires all parents, guardians and volunteers to be vaccinated for Influenza, Pertussis, TB skin test results and / or clearance, and Measles)  
\*Subject to change due to public health guidelines. Volunteer form can be found on page 30 of Parent/Guardian Preschool Handbook.**

### **AFTER THE REGISTRATION IS COMPLETED:**

- ☐ **Download the Learning Genie Parent App on your personal device.**
- ☐ **Attend the Preschool Orientation on August 16th, 2023.**

**ONLY COMPLETED PACKETS ALONG WITH THE REQUIRED DOCUMENTS WILL BE ACCEPTED. IF ADDITIONAL ASSISTANCE IS NEEDED, CONTACT Ms. Christina Lopez, [clopez@ljsd.org](mailto:clopez@ljsd.org)**

# LOWELL JOINT SCHOOL DISTRICT

PLEASE PRINT

## STUDENT INFORMATION FORM

COMPLETE ALL SECTIONS

Pupil's Name: _____			Entering Grade: _____		Current Date: _____	
Last	First	Middle	( )			
			Primary Phone Number			
Street Address		City	Zip	County	Parent/Guardian E-mail Address	
Birth Date: _____			<input type="checkbox"/> Male		<input type="checkbox"/> Female	
			Month		Day	
			Year			
School Last Attended: _____			Last Day of Attendance: _____			
Name						
School Address: _____			( )		( )	
Street Address			City	State	Phone Number	Fax Number

**Ethnic Identity:** Is this student Hispanic or Latino? (Select only one) ☐ No, not Hispanic or Latino ☐ Yes, Hispanic or Latino (Required by CA Gov Code Sec. 8310.5)

No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

- |                                                        |                                    |                                    |                                   |                                                 |                                     |
|--------------------------------------------------------|------------------------------------|------------------------------------|-----------------------------------|-------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Guamanian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Other Asian            | <input type="checkbox"/> Tahitian   |
| <input type="checkbox"/> Asian Indian                  | <input type="checkbox"/> Chinese   | <input type="checkbox"/> Hawaiian  | <input type="checkbox"/> Korean   | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Black or African American     | <input type="checkbox"/> Filipino  | <input type="checkbox"/> Hmong     | <input type="checkbox"/> Laotian  | <input type="checkbox"/> Samoan                 | <input type="checkbox"/> White      |

### FAMILY INFORMATION

Who has legal custody of this pupil? Father _____ Mother _____ Foster _____ ID # _____ Other _____					
Please specify					
Father/Guardian		Address (If different from above)		City	( ) <input type="checkbox"/> Cell or <input type="checkbox"/> Home Phone #
Father's Employer		Address		City	( ) <input type="checkbox"/> Cell or <input type="checkbox"/> Home Phone #
Mother/Guardian		Address (If different from above)		City	( ) <input type="checkbox"/> Cell or <input type="checkbox"/> Home Phone #
Mother's Employer		Address		City	( ) <input type="checkbox"/> Cell or <input type="checkbox"/> Home Phone #
Other Adult Living In the Home: _____					
Name					
Relationship					
Other Children Living in the Home:					
Name	Relationship	Date of Birth		Name	Relationship

**Parent Education Level (Please circle highest grade level completed)** Required by the Public Schools Accountability Act, Education Code Section 60630:

- |                                                              |                                                     |                                          |                                           |                                                              |                                                     |                                          |                                           |
|--------------------------------------------------------------|-----------------------------------------------------|------------------------------------------|-------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------|------------------------------------------|-------------------------------------------|
| <b>Father:</b> <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Not a High School Graduate | <input type="checkbox"/> Some College    | <input type="checkbox"/> College Graduate | <b>Mother:</b> <input type="checkbox"/> High School Graduate | <input type="checkbox"/> Not a High School Graduate | <input type="checkbox"/> Some College    | <input type="checkbox"/> College Graduate |
| <input type="checkbox"/> Graduate School                     | <input type="checkbox"/> Decline to State           | <input type="checkbox"/> Graduate School | <input type="checkbox"/> Decline to State | <input type="checkbox"/> Graduate School                     | <input type="checkbox"/> Decline to State           | <input type="checkbox"/> Graduate School | <input type="checkbox"/> Decline to State |

Was your child enrolled in a special program? Yes _____ No _____	
Type of services and/or program (please check): Special Education (IEP) _____ ELD _____ Gifted and Talented _____	
Speech/Language Therapy _____ 504 Plan _____ Other type of program not listed: _____	
Has your child ever attended school in Lowell Joint School District? Yes _____ No _____	
If yes, name of school: _____ Grade(s) attended: _____	
Did your child attend pre-school? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of pre-school: _____	

I certify that all information provided in this application and any supporting document(s) is true and correct.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

#### FOR OFFICE USE ONLY

Grid: _____	Teacher: _____	Enrollment Date: _____	Address Verified: _____
Permanent Records Requested: _____	Permanent Records Received: _____	Birth Date Verified By: _____	
Immunization Status: _____			

## TUITION-BASED PRESCHOOL PROGRAM FEES

**2023/2024**

Tuition-Based Preschool Program: 2023/2024	
Registration fee: \$ 150.00 per child	
Part Day/3 hour (M-F) Program Tuition Rates:	Monthly Rate
8:00 AM - 11:00 AM - Jordan Preschool	\$ 550.00
12:15 PM - 3:15 PM - Jordan Preschool	\$ 550.00
Full Day (M-F) Program Tuition Rates:	Monthly Rate
8:00 AM - 3:15 PM - Olita Preschool	\$ 850.00
8:00 AM - 3:15 PM - Macy Preschool	\$ 850.00

- 1st month's tuition is due on the first of each month, beginning August 1, 2023.
- A **30-day written notice** is required to cancel enrollment. Tuition **will not** be refunded or credited if proper written notice is not received 30 days prior to start.
- Fees are based on a 10 month enrollment. Prorated amounts **will not** be granted for non school days and fall/winter/spring breaks.
- Credit is not given for any day in which your child is absent from preschool.
- Tuition is due the **1st of each month** for the current month.
- **My School Bucks** account is required for registration and monthly payments. Video instructions available at link [My School Bucks Instructional Video](#) or step by step instructions are in the registration packet.
- Cash or cashiers check accepted.
- Personal check by request only. NSF fees and penalties may apply.



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Phone: 562) 943-0211 Fax: 562) 947-7874



LOWELL JOINT SCHOOL DISTRICT  
CHILD DEVELOPMENT SERVICES  
"Come Grow With Us"

## **FEE BASED CONTRACT 2023/2024**

- Registration Fee is \$150 per child.
- 1st month's tuition is due on the first of each month, beginning Aug 1, 2023 .
- A **30-day written notice** is required to cancel enrollment. Tuition **will not** be refunded or credited if proper written notice is not received 30 days prior to start.
- Fees are based on a 10 month enrollment. Prorated amounts **will not** be granted for non school days and fall/winter/spring breaks.
- Credit is not given for any day in which your child is absent from preschool.
- Tuition is due the **1st of each month** for the current month.
- **My School Bucks** account is required for registration and monthly payments. Video instructions available at link [My School Bucks Instructional Video](#) or step by step instructions are in the registration packet.
- Cash or cashiers check accepted.
- Personal check by request only. NSF fees and penalties may apply.

☐ Part Day Preschool Program-**Monthly Fee \$550.00**

☐ Full Day Preschool Program-**Monthly Fee: \$850.00**

I have read and understand the information stated above. I also understand non-payment will result in termination of enrollment in the preschool program.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
School Site

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

*District Office Staff Only:*

\_\_\_\_\_  
Department Coordinator Signature

\_\_\_\_\_  
Date Received

## Sign-up Information for My School Bucks

1. Go to [myschoolbucks.com](https://myschoolbucks.com)

2. Click on "sign up"

3. Create an account with your personal information (District: Lowell Joint School District)

Sign Up

Click on the "Sign Up" button

Lowell Joint School District

4. Click on "Create Account"

5. Verify account using text message

6. Go to your personal email used to create account and "validate email"

7. Log on to account using your "username" and "password"

8. Go to your profile (upper right)->

9. Click on My Students

10. Verify your student is on file. If no student,

Click Add Student (see video link/QR→

<https://watch.screencastify.com/v/r0Uf6DAFSymhpDbutZWP>

11. Click on "Invoices"

12. Select PowerSource Class(es)

13. Click on "Pay Selected Invoices"

14. Add new Payment Method if needed

15. Submit payment! (my school bucks processing fee will be added)

Questions? Contact PowerSource: [powersource@ljsd.org](mailto:powersource@ljsd.org)

PLEASE CHECK FOR INVOICE STARTING FRIDAY 11/4/22

## Información para Inscribirse en "My School Bucks"

1. Favor de ir a mis dolares escolares "myschoolbucks.com"

2. Presiona la tecla de firmar "sign up"

3. Cree una cuenta con su información personal (Distrito: Distrito Escolar Lowell Joint)

4. Presione la Tecla de "Create Account"

5. Verifique su cuenta usando un mensaje de texto

6. Acuda a su correo electrónico personal usado para crear la cuenta y presione validar correo "validate email"

7. Entre a su cuenta usando su nombre de usuario "username" y contraseña "password"

8. Vaya a su perfil (arriba a la derecha)

9. Presione la tecla de "My students"

10. Verifique que su estudiante está archivado, si no es así, presione "add student (ver enlace del

video/QR" <https://watch.screencastify.com/v/r0Uf6DAFSymhpDbutZWP>

11. Presione la tecla de "Invoices"(facturas)

12. Seleccione la tecla "PowerSource"para seleccionar clases

13. Seleccione pagar facturas seleccionadas "pay selected invoices"

14. Agregue un nuevo método de pago, si es necesario.

15. Envíe su pago (la tarifa por procesamiento en "my school bucks" será agregada).

¿Preguntas? Póngase en contacto a: [powersource@ljsd.org](mailto:powersource@ljsd.org)

CONSULTE POR FACTURA A PARTIR DEL VIERNES 11/4/22

School Year: \_\_\_\_\_

Name: \_\_\_\_\_ ☐ Male ☐ Female Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 Physician: \_\_\_\_\_ Physician Phone Number: \_\_\_\_\_  
 Health Insurance Plan: Private: \_\_\_\_\_ Medi-Cal: \_\_\_\_\_ None: \_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY**

**PAST MEDICAL HISTORY** ☐ None

- |                                                                |                                           |                                                  |
|----------------------------------------------------------------|-------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Premature Birth (35 weeks or earlier) | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Seizures / Epilepsy     |
| <input type="checkbox"/> Heart Defect/Heart Disease            | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> ADD/ADHD                |
| <input type="checkbox"/> Frequent Headaches                    | <input type="checkbox"/> Wears Glasses    | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Other: _____                          |                                           |                                                  |

**ALLERGIES** ☐ None ☐ Allergic to Bee/Wasp Stings

Food Allergies: ☐ Peanuts ☐ Milk ☐ Other: \_\_\_\_\_

Environmental Allergies: ☐ Latex ☐ Hay fever ☐ Household Animals ☐ Dust ☐ Grass ☐ Pollen ☐ Mold

**Type of Allergic Reaction:**

- ☐ Local Reaction - Pain, itching, minimal swelling and redness at site of contact  
☐ Systemic Reaction - Difficulty breathing, flushing of skin, rash, faintness

**Requires Epinephrine Pen at School?** ☐ Yes ☐ No

☐ Medication to treat Allergies (list Medicines): \_\_\_\_\_

**ASTHMA** ☐ NONE

Triggered by: ☐ Sickness ☐ Seasonal ☐ Exercise ☐ Other

Requires Medication: ☐ Daily ☐ As Needed ☐ Only With Exercise

Medications Required At School: ☐ Inhaler ☐ Nebulizer ☐ Other: \_\_\_\_\_

**ADDITIONAL MEDICAL INFORMATION** ☐ NONE

☐ Surgeries/Hospitalization: \_\_\_\_\_

☐ Illness: \_\_\_\_\_

☐ Physical Handicaps: \_\_\_\_\_

☐ Other: \_\_\_\_\_

**CURRENT DAILY MEDICATIONS** ☐ NONE

**WILL MEDICATIONS BE GIVEN AT SCHOOL?**

1. \_\_\_\_\_ ☐ YES ☐ NO

2. \_\_\_\_\_ ☐ YES ☐ NO

3. \_\_\_\_\_ ☐ YES ☐ NO

4. \_\_\_\_\_ ☐ YES ☐ NO

Please remember that **ALL** medications, including inhalers or over the counter substances have 3 requirements in order to be given at school. **1).** Parent permission **AND 2).** Physician order **AND 3).** Matching pharmacy label on bottle. Children are **NOT** permitted to carry **ANY** medication at school without permission from the doctor **AND** school nurse.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CHILDS HEALTH AND DEVELOPMENT SCREENING

### Medical Health

1. Do you have medical insurance for your child?

If yes: ☐ Medi-Cal ☐ Covered CA ☐ Kaiser ☐ Other:

2. Does your child have any chronic health issues such as asthma, diabetes, epilepsy?

Please explain:

☐ Yes ☐ No

3. Does your child have any allergies?

☐ Yes ☐ No

If yes, please indicate here: \_\_\_\_\_

4. Does your child take any medication?

☐ Yes ☐ No

If yes, please indicate here: \_\_\_\_\_

### Dental Health

1. Do you have dental insurance for your child?

☐ Yes ☐ No

If yes: ☐ Medi-Cal ☐ Covered CA ☐ Kaiser ☐ Other:

2. Has your child been seen by a dentist for a dental check-up within the last year? ☐ Yes ☐ No

Dental Clinic: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

3. Does your child brush his/her teeth two or more times a day? ☐ Yes ☐ No

### Hearing and Vision

1. Does your preschooler hear and understand most of what is said at home? ☐ Yes ☐ No

2. Does your preschooler speak so that he or she can be understood most of the time? ☐ Yes ☐ No

3. Does your preschooler currently wear corrective lenses / glasses? ☐ Yes ☐ No

### Growth and Nutrition

1. Does your child eat five or more servings of fruits and vegetables each day? ☐ Yes ☐ No

2. Does your child watch TV more than two hours a day? ☐ Yes ☐ No

3. Is your child physically active for a total of 60 minutes or more each day? ☐ Yes ☐ No

### Developmental

1. Is your child's growth and development within schedule? ☐ Yes ☐ No

2. Does your preschooler use 3 or 4-word sentences? ☐ Yes ☐ No

3. Have you observed your child having difficulty doing things expected for his/her age? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

4. Has your child ever received services such as speech, physical, occupational therapy? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

## PARENT CONSENT FOR HEALTH SCREENING

Lowell School District is providing evaluations through the California State Preschool Program. The screenings will assist the School Readiness Nurses in identifying children who may need referrals for medical intervention. Your written consent is required for the nurses to conduct any of these screenings with your child. The School Readiness Nurses are also available to assist you if you are in need of health insurance and/or other community resource services. This screening is not intended to replace any medical evaluation. It has a limited scope and is not designed to uncover all problems. Lowell School District is not responsible for treatment or therapy for conditions uncovered by this screening.

The following screenings and services will be provided throughout the school year:  
(circle yes or no)

- Hearing                      Yes              No
- Vision                      Yes              No

Health information may be shared with appropriate school personnel              Yes              No

Health information concerning my child may be released to the appropriate agencies assisting in the care of my child and the school my child will be attending after preschool.              Yes              No

With my signature below, I give my consent for screenings listed above. I understand that I will be provided with a written report.

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For further information about mental health screenings, please contact the school readiness nurse.

The School Readiness Nurse Program is funded by a grant provided by The Children & Families Commission of Orange County



## ETHNICITY, RACE & LANGUAGE SURVEY

The Federal Government requires a **two-part question** to collect race and ethnicity data on all students. Such data is summarized, AND TOTAL FIGURES ARE USED FOR SCHOOL AND DISTRICT REPORTING PURPOSES. The California Department of Education requests your input on home language. **COMPLETE ALL SECTIONS.**

**ETHNICITY** Mark the ethnicity with which the student most closely identifies.

☐ Hispanic / Latino (A person of Cuban, Mexican, Puerto Rican, South or Central America or other Spanish culture or origin, regardless of race)

☐ Not Hispanic / Latino

**RACE** Please check ONE OR MORE of the selections indicating which race(s) the student most closely identifies.

<input type="checkbox"/> <b>American Indian or Alaskan Native</b>  (Person having origins in any of the original peoples of North and South America, including Central America)	<b>Asian</b> <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Other Asian	<b>Native Hawaiian or other Pacific Islander</b> <input type="checkbox"/> Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Tahitian <input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> <b>Black or African American</b>	<input type="checkbox"/> <b>White</b>  (Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East)
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------

**LANGUAGE:** Complete the following 4 questions

- 1) Which language(s) does your child hear at home? \*This includes the language(s) spoken by parents, grandparents, siblings, extended family, or others living within or visiting the home \_\_\_\_\_
- 2) Which language(s) does your child hear in their neighborhood / community? \*For example, with friends and neighbors, at church or after school programs or activities. This is to demonstrate language exposure, not to measure language proficiency. \_\_\_\_\_
- 3) Which language(s) does your child understand? \_\_\_\_\_
- 4) Which language(s) does your child speak? \_\_\_\_\_

Name of Student: \_\_\_\_\_  
Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## SURVEY FOR FAMILY INTERESTS AND NEEDS

Student Name: \_\_\_\_\_

INFORMATION ABOUT	YES	NO	NOTES
Healthy food and nutrition classes			
Low cost clinics			
Disease prevention			
Health insurance for children			
Family dental insurance			
Places that provide legal assistance			
Places that provide emergency food			
Classes on Positive Parenting Strategies			
How to support your child to be successful in school			
School Readiness			
Domestic Violence			
Social Services, WIC, etc.			
Mental Health			
Dual Language Academy in the Fullerton School District			
Gifted and Talented Education Program (GATE)			
Other Programs in the Fullerton School District			
Community programs for children			
Do you need information on any other topic?			

Are you interested in participating in the P.A.C. (Parent Advisory Committee?)	YES	NO
--------------------------------------------------------------------------------	-----	----

Please circle the position of your interest:			
President	Vice President	Secretary	Classroom Representative

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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LOWELL JOINT SCHOOL DISTRICT  
CHILD DEVELOPMENT SERVICES  
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## **PHOTO/PUBLICITY PERMISSION**

**2023/2024**

The Lowell Joint School District (LJSD) is known for its outstanding and talented students. From time to time, the district would like to publicize their achievements for the purpose of positive public relations. Because these events and interviews are almost always needed at the last moment, we are requesting parental permission for the 2023/2024 school year, rather than on a case-by-case basis.

Please note that when the media is on campus, we cannot prohibit them from interviewing students or including them in photographs or news stories. This permission form is for the district to issue publicity.

- ☐ I **give** my permission for my child to be featured in district-issued publicity, including district publications, the district website and announcements.
- ☐ I **do not give** my permission for my child to be featured in district-issued publicity, including district publications, the district website and announcements. However, I **do give** permission for my child to be included in the yearbook, honor roll and other school-issued publicity.

If you do not give permission for your child to be photographed, please make sure that your child is aware of this decision.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Student Name (please print)

\_\_\_\_\_  
School Site

\_\_\_\_\_  
Date

## **AUTHORIZATION OF THE ADMINISTRATION OF SUNSCREEN**

**2023/2024**

Name of Child \_\_\_\_\_

Date of Birth \_\_\_\_\_

In order for LJSD Preschool Staff to apply sunscreen to your child, you will need to provide the sunscreen you prefer, as well as this completed form, to your child's Teacher. **PLEASE, CLEARLY MARK YOUR CHILD'S NAME IN PERMANENT MARKER ON THE BOTTLE/TUBE.**

We will keep the sunscreen on site and will assist your child in applying sunscreen. Please replenish sunscreen as needed.

I hereby give permission for LJSD Preschool Staff to assist my child in applying sunscreen as needed.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
School Site

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

## On Campus Field Trip Parent Permission Form

**2023/2024**

Dear Parent or Guardian,

The preschool programs that are part of the Lowell-Joint School District are licensed preschool programs. There are specific areas and buildings on campus that are licensed. Because of our unique position on the elementary school campuses, we have access to many opportunities outside of the licensed facilities.

In order for our children to participate in these programs and go into the unlicensed facilities on our campus, we are asking for parent permission to go to facilities on the campus that are not licensed. For the purpose of this, we are calling these "**off-site**" field trips. This means that your child will be **off of the licensed site**.

When children go "**off-site**", they will remain in the care of their regular preschool teachers. While away from the licensed facility on campus, children will remain in the appropriate safety ratios. This paperwork will accompany the staff that is supervising your child.

Some of the "**off-site**" field trips may include school pictures, assemblies, preschool activities, rewards for school fundraisers, preschool health and developmental screenings, kindergarten readiness screenings, or other whole school activities.

Some areas of the school campus that may be visited include the cafeteria, the multi-purpose room, the main school office, shared outdoor spaces such as the field, the school library, or other school facilities.

---

**Child's Name**

My child has permission to leave the licensed facilities of the Jordan/Olita/Macy Elementary School campus.

I understand that my child will be out of the licensed preschool facilities. I understand that my child will remain in the appropriate teacher to student ratio while out of the licensed facilities on the school campus. My emergency contact information in my child's preschool file will accompany the teacher for the duration of the activity.

---

Parent/Guardian Signature

---

School Site

---

Print Name

---

Date

**Lowell Joint School District  
Preschool Admission Agreement**

**As the parent or legal guardian of the below named student, my initial and signature signifies that I understand, agree to, and/or acknowledge the following:**

A. I have reviewed a copy of the Parent Handbook and will comply with the policies set forth (Parent Handbook is available on the LJSD website.) \_\_\_\_\_

B. I have reviewed, signed, and understand the On-Campus Field Trip Permission Slip. \_\_\_\_\_

C. LJSD staff and volunteers are not allowed to babysit or transport children at any time outside of the LJSD Preschool Program. \_\_\_\_\_

D. I am not to leave my child at the LJSD preschool classroom unless a LJSD teacher is there to receive and supervise my child. \_\_\_\_\_

E. Should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police. (Please do not put staff in a position where they have to make this judgment call.) \_\_\_\_\_

F. LJSD is mandated by state law to report any child abuse or neglect to the appropriate authorities for investigation. \_\_\_\_\_

G. LJSD may terminate my child's enrollment for any of the following reasons. \_\_\_\_\_

- Emergency contact names and phone numbers are incorrect,
- Parent/Guardian is continually late picking up the child after the LJSD session ends.
- Non/Late/NSF payment of tuition fees.
- Failure to adhere to the sign in/out procedures.
- Failure to notify LJSD school site that the child will be absent.
- Child leaving the LJSD school site without authorized written permission.
- Behavior that is continually disruptive or dangerous to others and/or self.
- Behavior that is destructive to property and/or refusal to replace said property.
- Any single incident that is deemed by the Program Coordinator to be dangerous, harmful, or disruptive.
- Harassment, violent behavior or treatment of such behaviors against a staff person or other members by parent/guardian or persons associated with the child (family member, family friend, etc.)

H. Program participation requires a LJSD in good standing. Non-payment of fees will result in my child not being allowed to participate in the program and could result in legal referral with additional costs to myself. I further understand that there is an administrative processing fee for any payment returned by my bank or credit account. Refunds and/or credits are not given for any day in which a child does not attend the program including school closures or seasonal breaks. \_\_\_\_\_

I. LJSD and the staff employed by the LJSD will not become involved in any custodial disputes between parent/guardian. If LJSD documents are requested, the court must request them. The staff's responsibility is to provide a safe environment for children. \_\_\_\_\_

J. I understand that I am required to give a 30-day written notice when terminating from the JLSD Preschool Program. **If 30-day written notice is not given, I will not receive a refund or credit.** \_\_\_\_\_

K. Children and staff have the option to wear a mask during the preschool program. \_\_\_\_\_

L. 48 hour fever free clearance will be required prior to children returning to program participation. \_\_\_\_\_

M. **All children must be 100% potty trained and able to use the restroom unassisted.** This includes independently removing clothing, wiping independently, refastening clothing and hand washing. Please be reasonably sure that your child has demonstrated that they are physically ready. In extreme cases, parents will be contacted to assist their child. \_\_\_\_\_

N. **The Community Care Licensing Division of California Department of Social Services (Section 101200)** has the authority to interview children or staff to inspect and audit child or facility records without prior consent. The licensee shall make provisions for private interviews with any child(ren) or any staff member and for the examination of all records relating to the operation of the facility. The licensing agency has the opportunity to observe the physical condition of the child(ren), including conditions that could indicate abuse, neglect, or inappropriate placement. \_\_\_\_\_

Child's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Lowell Joint  
School District**

*A Tradition of Excellence Since 1906*

**"Home of Scholars and Champions"**



LOWELL JOINT SCHOOL DISTRICT  
CHILD DEVELOPMENT SERVICES  
"Come Grow With Us"

## **Preschool Uses Learning Genie!**

Dear Preschool Families,

The Preschool Program uses the **Learning Genie's Digital Sign In/Out Attendance Reporting and Daily Health Card Screening**.

\*The Daily Health Card feature will be implemented if recommended by CDC's health guidelines.

Parents or guardians **must** submit a digital Daily Health Card **BEFORE** entering the classroom. The Daily Health Card may be completed from home on your mobile device or other electronic device using the Learning Genie application. If you are unable to complete the Daily Health Card from home, an iPad will be available outside of the classroom for your use.

Upon arrival at the classroom, staff will review the Digital Daily Health Card information and check your healthy child in.

The Learning Genie application is designed to protect your children, keep you informed, and adhere to health screening and social distancing regulations. The Daily Health Card screening will build trust, help provide peace of mind, and instill confidence within our school community. Learning Genie improves communications between teachers and student's families. Through this application, we will be able to update you on your child's learning progress, send photos and reports, and provide ways for you to continue enhancing your child's early learning at home. Preschool staff will only share photos of your child in group photos with your child's class. **Your child will be excluded from shared class photos if you have a signed non-consent form in your child's file.**

Please become part of this experience! All you need to do is download the free mobile application on your iPhone or Android device. It is also available for your home computers and iPads. The application is labeled "**Learning Genie For Parents**" Preschool Staff will provide you with an access code to log in into your account.

**Preschool Personnel  
Lowell Joint School District  
[www.preschool.ljsd.org](http://www.preschool.ljsd.org)**





## **Learning Genie: The Basics**

**Sign in/Sign out Remotely.** This is the main tool to be used by our parents for the child's drop off and pick up process and the reporting of absences.

**Get updates on your child's day.** Receive real-time updates and photos on our devices. Summary reports are sent to your email regularly.

**Continue the learning at home.** Learning activities and video books shared through the application allow families to expand on the child's learning from home.

**Two-way messaging.** Teachers and families can chat instantly, with translations of multiple languages, so no one gets left out.

**Safe for Everyone.** All of your child's information is kept secure and confidential on the Learning Genie platform. Learning Genie's software is protected through secure-socket layering via Amazon Web Services, is compliant with HIPAA and FERPA regulations, and has obtained the iKeepSafe California Student Privacy Badge.

### **\* Daily Health Card Screening.**

Answer the screening questions as accurately as possible. Your information will be handled confidentially. Additionally, please have **alternate plans for emergencies** in the event your child is not permitted to stay for class. Together we are working to protect our children, school environment, and community to be as safe as possible.

\*This feature will be implemented if recommended by CDC's health guidelines.

## **Frequently Asked Questions by Families**

### **How do I sign up for a Learning Genie Parent Account?**

- You will receive a code from the Preschool Staff
- Download the Learning Genie Parent Application on your device
- Sign in with your parent code.

### **How long is my child's data saved in the system?**

- Your data will be retained in the system up to three years after children leave preschool.
- The data will be removed if preschool chooses to permanently delete children's information.

### **What if I have more than one child using Learning Genie in separate classrooms?**

- Learning Genie assigns each child a separate parent code. Each parent application can have multiple children attached.

### **What are the best practices for using Learning Genie for social media?**

- Learning Genie recommends that families approach public social media with caution.
- Posting photos of other children in any public space compromises those children's privacy.
- If you decide to share a picture, please share those of your child only.

## PERSONAL RIGHTS

### Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
  - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
  - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
  - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
  - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
  - (6) Not to be locked in any room, building, or facility premises by day or night.
  - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

### Community Care Licensing Division

NAME

Orange County Child Care Regional Office

ADDRESS

750 The City Drive South, Suite 250

CITY

Orange

ZIP CODE

92868

AREA CODE/TELEPHONE NUMBER

(714) 703-2800

DETACH HERE

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:

**PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

**ACKNOWLEDGMENT:** I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

Lowell Joint School District - Macy Preschool

(PRINT THE ADDRESS OF THE FACILITY)

2301 Russell St, La Habra, CA 90631

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

## CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Lowell Joint School District - Macy Preschool TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

NAME \_\_\_\_\_ THIS CARE MAY BE GIVEN UNDER \_\_\_\_\_

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD  
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE \_\_\_\_\_

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE \_\_\_\_\_

HOME ADDRESS

HOME PHONE

( )

WORK PHONE

( )

## IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
BIRTHDATE					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ( )					
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
HOME TELEPHONE ( )					
PERSON RESPONSIBLE FOR CHILD	LAST	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

### ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

### PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL      ☐ OTHER    EXPLAIN: \_\_\_\_\_

**NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY**  
(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN  
AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE

DATE

**TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY  
CHILD CARE HOMES LICENSEE**

DATE OF ADMISSION

LAST DATE OF ENROLLMENT

**PHYSICIAN'S REPORT—CHILD CARE CENTERS**  
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)**PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)**

\_\_\_\_\_, born \_\_\_\_\_, is being studied for readiness to enter  
(NAME OF CHILD) (BIRTH DATE)

\_\_\_\_\_. This Child Care Center/School provides a program which extends from \_\_\_\_\_ : \_\_\_\_\_  
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to \_\_\_\_\_ a.m./p.m. , \_\_\_\_\_ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

\_\_\_\_\_  
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

\_\_\_\_\_  
(TODAY'S DATE)

**PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)**

Problems of which you should be aware:

Hearing:

Allergies; medicine:

Vision:

Insect stings:

Developmental:

Food:

Language/Speech:

Asthma:

Dental:

Other (Include behavioral concerns):

Comments/Explanations:

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

**IMMUNIZATION HISTORY:** (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
(REQUIRED FOR CHILD CARE ONLY)					
HIB MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

**SCREENING OF TB RISK FACTORS** (listing on reverse side)

- ☐ Risk factors not present; TB skin test not required.
- ☐ Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).  
\_\_\_\_\_ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_

Date This Form Completed: \_\_\_\_\_

Signature \_\_\_\_\_

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

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**RISK FACTORS FOR TB IN CHILDREN:**

- \* Have a family member or contacts with a history of confirmed or suspected TB.
  - \* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
  - \* Live in out-of-home placements.
  - \* Have, or are suspected to have, HIV infection.
  - \* Live with an adult with HIV seropositivity.
  - \* Live with an adult who has been incarcerated in the last five years.
  - \* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
  - \* Have abnormalities on chest X-ray suggestive of TB.
  - \* Have clinical evidence of TB.
- 

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

## CHILD'S PREADMISSION HEALTH HISTORY - PARENT/AUTHORIZED REPRESENTATIVE REPORT

CHILD'S NAME	SEX	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
PARENT / AUTHORIZED REPRESENTATIVE NAME		DOES PARENT / AUTHORIZED REPRESENTATIVE LIVE IN HOME WITH CHILD?
IS / HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/ MEDICAL EXAMINATION

### DEVELOPMENTAL HISTORY *(\*For infants and preschool-age children only)*

WALKED AT* _____ MONTHS	BEGAN TALKING AT* _____ MONTHS	TOILET TRAINING STARTED AT* _____ MONTHS
----------------------------	-----------------------------------	---------------------------------------------

### PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping Cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF

**DAILY ROUTINES** (\*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*	
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*	
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST		
	LUNCH		
	DINNER		
WHAT ARE USUAL EATING HOURS?	BREAKFAST		
	LUNCH		
	DINNER		
ANY FOOD DISLIKES?		ANY EATING PROBLEMS?	
IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*		WORD USED FOR URINATION*	

## PARENT / AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT KIND:

## PARENT/ AUTHORIZED REPRESENTATIVE EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENT / AUTHORIZED REPRESENTATIVE, BROTHERS,  
SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE

DATE

## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

### PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: Orange County Child Care Regional Office

Licensing Office Address: 750 The City Drive South, Suite 250, Orange, CA 92868

Licensing Office Telephone #: (714) 703-2800 8:00am - 5:00pm

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

**NOTE:** CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

### ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of \_\_\_\_\_, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

Lowell Joint School Dist. - Olita or Macy Preschool  
Name of Child Care Center

\_\_\_\_\_  
Signature (Parent/Authorized Representative)

\_\_\_\_\_  
Date

**NOTE:** This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)

## Residency Verification 2023/2024

☐ Homeowner ☐ Renter ☐ Co-Residency ☐ Other: \_\_\_\_\_

Parent(s) / Guardian(s) Name: \_\_\_\_\_  
Last Name
First Name
Middle Name

Address: \_\_\_\_\_  
Number
Street
Apt. #
City
Zip Code

*Please provide the following documents **under your name** to establish residency.*

One (1) of the following

Or

Two (2) of the following

<input type="checkbox"/> Correspondence from government Agency. (E.g. Social Security, DMV, Cal Works Letter, Cal Fresh Letter, Medical Letter, EDD, WIC Letter, etc.) <input type="checkbox"/> Deed to Home <input type="checkbox"/> Mortgage Escrow Paperwork <input type="checkbox"/> Rental Lease Agreement <input type="checkbox"/> Property Tax Bill o Tax Return	<input type="checkbox"/> Drivers' License / California Identification Card <input type="checkbox"/> Current Automobile Insurance Policy <input type="checkbox"/> Current Payroll Stub <input type="checkbox"/> Current Electric Bill <input type="checkbox"/> Current Gas Bill <input type="checkbox"/> Current Water Bill <input type="checkbox"/> Current Waste Management Bill <input type="checkbox"/> Current Cable Bill
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

*If you cannot provide proof of residency **under your name**, please have the primary resident/owner of the shared home provide the documents listed above in addition to completing the section below.*

### Co-Resident

I, \_\_\_\_\_ declare that I am the primary resident/Owner of  
Full Name of Primary Resident /Owner

the address listed above and that the person(s) claiming the address reside(s) with me at least five (5) days per week. I further declare that all of the information provided in this Residency Verification Affidavit, including information provided by the parents)/ guardian(s), is true and correct. I will submit the required documents to verify my residency. I agree to notify Lowell Joint School District if there are any changes in the status of the residency of the person(s) claiming the address or myself.

**I swear (or certify) under penalty of perjury that the foregoing is true and correct.**

\_\_\_\_\_  
Signature of Primary Resident / Owner

\_\_\_\_\_  
Date